Division of Health Care Facilities

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN0103	A. BUILDING: _____ B. WING _____	04/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENT	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments Based on an annual Licensure survey and investigation of complaint #38416 conducted 4/18/16 through 4/25/16 the facility was cited a Type "A" penalty for failure to ensure a systematic process was followed for preventing significant medication errors and following physician orders for administration of medications. The facility's failure resulted in significant medication errors for 7 residents (#22, #150, #169, #178, #31, #93, and #177) of 16 residents placing the residents in an environment detrimental to their health, safety, and welfare. The Administrator and the Director of Nursing were informed of the findings which were detrimental to their health, safety, and welfare on 4/25/16 at 10:50 AM, in the Director of Nursing's office. The findings were effective 3/17/16 and were ongoing.	N 000	**N401** **Corrective Action**: The administration and administrator are reviewing medication variances, Consultant Pharmacy Reports, and evaluating for trends. The administrator is involved in the root cause analysis and developing performance improvement projects. This is an ongoing review, however there have been no issues identified. **Identification/Corrective Action**: Administration and administrator is reviewing medication variances, Consultant Pharmacy Reports, and evaluating for trends for the benefit of all residents. Administration is involved in the root cause analysis and developing performance improvement projects for the benefit of all residents. **Measures/Systemic Changes:** The administrator and DON have been educated on 4-27-16 by the regional nurse consultant regarding medication management. The District Director of Operation and the District Director of Clinical Services will meet with the	
N 401	1200-8-6-.04(1) Administration (1). The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.	N 401		

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N 401	Continued From page 1 This Rule is not met as evidenced by: Based on medical record review, review of the Medication Variance Record and interview, the facility failed to be administered in a manner to ensure significant medication errors did not occur for 7 residents (#22, #150, #169, #178, #31, #93, #177) and failed to ensure pain medication was administered prior to wound care for 2 (#150, #169) residents of 16 residents reviewed for medication administration. The facility's failure to ensure significant medication errors did not occur placed resident (#22, #150, #169, #178, #31, #93, #177) in an environment detrimental to their health, safety, and welfare. The findings included: Interview with the Administrator on 4/25/16 at 1:24 PM, in the conference room confirmed the Administrator had not been involved in the process related to medication errors.	N 401	Administrator and Director of Nursing on a weekly basis in person or by phone for one month to assure that the Administrator and Director of Nursing are aware of their roles and responsibilities and to review progress with this plan. **Monitor/QA:** Administration will be participating in root cause analysis projects and performance improvement plans based on the audits and medication variances. These audits will be present monthly by the DON or designee and the consulting pharmacist to the QAPI committee attended by Administrator, DON, Medical Director, Unit Managers, Rehab Director, MDS, Consultant Pharmacist, Social Services Director, Maintenance Director, and Housekeeping Director.	5-27-16
N 601	1200-8-6-.06(1)(a) Basic Services (1) Performance Improvement. (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. This Rule is not met as evidenced by: Based on medical record review and interview, the Quality Assurance (QA) Committee failed to	N 601		

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N 601	Continued From page 2 identify and develop plans of action to ensure physician orders and medications were administered as ordered for 7 residents (#22, #150, #169, #178, #31, #93, #177) of 16 residents reviewed for medication administration. The facility's failure to ensure significant medication errors did not occur placed 7 residents (#22, #150, #169, #178, #31, #93, #177) in an environment detrimental to their health, safety, and welfare. The findings included: Interview with the Administrator on 4/25/16 at 11:00 AM, in the DON's office confirmed the QA Committee had not identified medication errors as a problem. Further interview confirmed the facility failed to ensure the nurses were following the physician orders and medicating the residents as ordered. Interview with the Administrator on 4/25/16 at 11:05 AM in the DON office confirmed pain was identified as a problem but the QA Committee did not develop a plan of care to identify the residents not getting medications as ordered. Further interview confirmed the facility did not develop an audit to identify specific medications or audit medications administered and to ensure the medications were administered as ordered.	N 601	**N601** **Corrective Action**: Education was provided to the QAPI Committee on 4-25-16 and 4-27-15, to include involvement in the areas of medication management administrative functions, medication management advisory committee, medication variances, pain management, and performance improvement project/root cause analysis for compliant/safe medication administration. **Identification/Corrective Action**: The Quality Assurance Performance Improvement Committee was advised and educated on 4-25-16 and 4-27-16, regarding their responsibilities, the development of root cause analysis, and the formulation of performance improvement plans, for the benefit of all residents. **Measures/Systemic Changes:** Quality Assurance Performance Improvement Committee will conduct monthly meetings using the Agenda and tools provided in the toolkit with	
N 615	1200-8-6-.06(2)(d)3. Basic Services (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall:	N 615		

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N 615	1200-8-6-.06(2)(d)3. Basic Services (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall:	N 615		

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N 615	Continued From page 3 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on review of the Medical Director Services Agreement, facility policy review, review of facility investigations, medical record review, and interview, the facility failed to ensure the Medical Director participated in the development and implementation of resident care policies to ensure Physician orders were followed and medications were administered as ordered. The facility's failure placed 7 residents (#22, #150, #169, #178, #31, #93, #177) in an enviornment detrimental to their health, safety, and welfare. The findings included: Review of the Medical Director Services Agreement revealed "...Duties & [and] Responsibilities of Medical Director...Coordinate medical care in the Facility to insure the adequacy and appropriateness of the medical services provided, for example: Assist the Administrator and Director of Nurses in clinical program development and act as a consultant to the Director of Nurses in matters relating to resident care..." Interview with the Medical Director on 4/25/16 at 10:35 AM, in the conference room revealed when asked what recommendations the Medical Director had made to the facility related to medication errors the Medical Director replied the nurses needed to be accountable for their	N 615	**N615** **Corrective Action**: Education was provided to the Medical Director on 5-1-16 to include involvement in the areas of medication management administrative functions, medication management advisory committee, medication variances, pain management, and performance improvement project/root cause analysis for compliant/safe medication administration. **Identification/Corrective Action**: The Medical Director was advised and educated on 5-1-16 regarding her responsibilities, for the benefit of all residents. **Measures/Systemic Changes:** On 5/1/2016: Medical Director reviewed findings of alleged non-compliance; Medical Director approved process of medication reconciliation, transcription, and documentation; Medical Director during facility visits will observe Medication Administration Records to audit transcription; The Medical	

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N 615	Continued From page 4 mistakes and "What other people do is out of my hands."	N 615	**N685** **Corrective Action**: Resident #22 received an assessment and treatment by the Nurse Practitioner, and was transferred to the hospital on 3-18-16. Resident #93 had a transcription error which was identified and corrected on 3-8-16. Resident #177 has been discharged Licensed nurses were educated on 4-26,4-27, and 4-28-16 by DON, Unit Manager, and DDCS, regarding medication administration and emergency drug box usage. Residents #150 and #169 have been discharged. The wound care nurse was instructed on 5-3-16 by the DON to communicate with medication nurse the time wound care would be done and to follow-up. Resident #169 has been discharged. Resident #31 has been discharged. Resident #178 has been discharged. **Identification/Corrective Action**: All residents have the potential to be affected by transcription errors, omission of medication, and incorrect	
N 685	1200-8-6-.06(4)(i) Basic Services (4) Nursing Services. (i) All drugs, devices and related materials must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Rule is not met as evidenced by: Based on facility policy review, medical record review, review of Medication Variance Report, observation, and interview, the facility failed to prevent significant medication errors for 7 (#22, #150, #169, #178, #31, #93, #177) of 16 residents reviewed for medication administration of 42 residents reviewed. The facility's failure placed 7 (#22, #150, #169, #178, #31, #93, #177) residents in an environment which was detrimental to their health, safety, and welfare. The Administrator and the Director of Nursing were informed of the findings which were detrimental to their health, safety, and welfare on 4/25/16 at 10:50 AM, in the Director of Nursing's office. Review of facility policy, Medication Administration, revised 6/08 revealed "Resident Medications are administered in an accurate, safe, timely, and sanitary manner...Medications are administered in accordance with written orders of the attending physician...Verify the	N 685		

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N 685	Continued From page 5 medication label against the medication sheet for accuracy of drug frequency, durations, strength, and route. The nurse is responsible to read and follow precautionary or instructions on prescription labels. If the label and medication sheet are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule..." Medical record review revealed Resident #22 was admitted to the facility on 6/7/10 and readmitted on 3/23/16, after admission to the hospital after and an overdose of Morphine sulfate at the facility, with diagnoses including Chronic Pain Syndrome, Vascular Dementia, Diabetes Mellitus, Left Below the Knee Amputation, Depression, Iron Deficiency Anemia, Morbid Obesity, Hypertension, Peripheral Vascular Disease, Bipolar Disorder, Congestive Heart Failure, Coronary Artery Disease, Unspecified Psychosis, and Hypokalemia. Medical record review of the March 2016 Physician's Recapitulation Orders revealed "...Morphine [opiate narcotic analgesic, can cause respiratory distress and death when taken in high doses] sol [solution] w/syr [with syringe]...20 mg. [milligrams]/1 ml. [milliliter] solution...1.25 mls (25 mg) sublingually [under the tongue] five times daily routine (7 AM, 12 PM, 5 PM, 10 PM, 3 AM)..." Medical record review of a prescription for Resident #22 dated 3/10/16 revealed "Morphine sulfate 20 mg/5 ml, 6 ml PO/SL [by mouth/sublingually] at 7 AM, 12 PM, 5 PM, 10 PM, and 3 AM..."	N 685	dosages. The nursing staff has audited to ensure orders are clarified for the five identified residents. None of the five residents experienced adverse outcomes. 100% audit of physician orders and MARs was completed on 4/25/16. Licensed nurse's education and competency tests were completed on 4-28-16. **Measures/Systemic Changes**: A 100% audit of Physician Order Sheets and MARs were completed on 4-25-16 by Unit Managers and DON, etc. Licensed nurses were educated on 4-26, 4-27, and 4-28 by the Unit Manager, DON, and DDCS on medication administration including the 7 rights, transcript, and documentation. Daily MAR audits are being conducted by Nurse Managers and DON five times a week. This process is ongoing. Clinical Stand up Meeting is attended by DON, Unit Managers, MDS Coordinator, Rehab Manager, Dietary Manager, and Activity Director to review physician orders for correct transcription onto MARs. New employees will be educated during	

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N 685	Continued From page 6 Medical record review of the 3/16 Medication Record revealed on 3/10/16 the Morphine Sulfate 20 mg/5 ml, 6 ml PO/SL at 7 AM, 12 PM, 5 PM, 10 PM, and 3 AM was transcribed onto the Medication Record to reflect the change in the concentration/strength of the Morphine solution. Review of a Medication Variance Report dated 3/18/16 at 10:00 AM revealed Resident #22 received the wrong dose (concentration/strength) of Morphine Sulfate. Continued review of the Medication Variance Report revealed the resident was to receive Morphine with a strength of 20 mg/5 ml oral solution, with a dose of 24 mg/6ml, but had received Morphine 20 mg/ml with a dose of 120 mg/6 ml for 4 doses. Continued review of the Medication Variance Report revealed "...Outcome...hospitalization...temporary change in level of consciousness...An error occurred that may have contributed to or resulted in temporary resident harm or required initial or prolonged hospitalization..." Review of the Individual Patient's Controlled Substances Record for Resident #22 revealed on 3/17/16 Morphine Sulfate Solution 20 mg/ml was obtained from the facility's emergency supply. Continued review of the Individual Patient's Controlled Substances Record revealed Licensed Practical Nurse (LPN#1) signed out 6 ml (120 mg) of the Morphine Sulfate solution for administration to Resident #22 on 3/17/16 at 12:00 PM, 5:00 PM, and 10:00 PM. Continued review of the Individual Patient's Controlled Substances Record revealed LPN #2 signed out 6 ml (120 mg) of the Morphine Solution for administration to Resident #22 on 3/18/16 at 3:00 AM.	N 685	orientation on the order transcription process. No employees will work prior to having education. **Monitor/QA**: Random audits will be conducted monthly by consulting pharmacist of physician orders, mediation carts, and nurse medication administration. DON or designee will perform weekly audits of medication administration until 100% compliance is achieved. Results of the audits will be presented monthly to QAPI Committee members consisting of Administrator, DON, Medical Director, Unit Managers, Rehab Director, MDS, Consultant Pharmacist, Social Services Director, Maintenance Director, and Housekeeping Director.	5-27-16

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N 685	Continued From page 7 Medical record review of the 3/1/16 through 3/31/16 Medication Record revealed on 3/18/16 the Morphine Sulfate 20 mg/5 ml, 6 ml po/sl was circled as not administered at 7:00 AM. Medical record review of a nursing note dated 3/18/16 revealed "7AM CNA [Certified Nursing Assistant #7] reports res. [resident] 'acting funny.' Spoke with res & [and] he talked cheerful & knew this nurses name. No distress at present...10 AM-Upon entering room-res presents with decreased LOC [level of consciouness]. NP [Nurse Practitioner] & RN [Registered Nurse] Sup [supervisor] notified & following orders in MD [Medical Doctor] orders...12p Res. alert with resp [respirations] @ [at] 16, knows staff & agrees for further TX [treatment] & eval [evaluation] to be trans [transferred] to [named hospital]..." Medical record review of the NP progress note dated 3/18/16 revealed "...BP [blood pressure] 112/50...HR [heart rate] 80...RR [respiratory rate] 4 rpm [respirations per minute] Temp [temperature] 101.4 O2 [oxygen] Sat [saturation] 93% [percent]...RA [room air]...wheezing...awake, able to verbalize...Narcan [opiate antidote] 0.8 mg IM [intramuscular] given, did not respond, another 0.8 mg given & respirations up to 12/min [minute]. Another 1 mg Narcan given & he improved to 16/min then O2 sat dropped to 83%, O2 applied at 2 LPM [liters per minute] & O2 remains at 93%, B/P dropped to 60/40 then improved, 1 mg Narcan given & he briefly improved for several minutes, then resp. [respirations] decreased with 10 sec. [seconds] periods of apnea-Sent to ER [emergency room]...1. Acute Respiratory Distress [difficulty breathing requiring medical intervention]. 2. Hypoxemia [low level of oxygen]. 3. Encephalopathy [malfunction of the brain manifested by an altered mental state]. 4.	N 685		

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N 685	Continued From page 8 Hypotension [low blood pressure]. 5. Dyspnea [difficult or labored breathing, shortness of breath]..." Medical record review of a NP order dated 3/18/16 at 10:40 AM revealed "Narcan 1.6 mg IM [intramuscular injection] now, O2 to keep sats [saturation level] at 92% or above, PCXR [portable chest x-ray]-wheezing, fever, Duoneb [inhalation respiratory treatment] 1 unit dose now, Narcan 1 mg IM again now..." Medical record review of a NP's order dated 3/18/16 at 11:00 AM revealed "...Hold Morphine, Give 2 mg Narcan now." Medical record review of a NP's order dated 3/18/16 at 11:30 AM revealed "Send to ER." Medical record review of an Emergency Department note dated 3/18/16 revealed "...The patient presents to the emergency department after a known overdose, that was accidental...Pt [patient] was at his rehabilitation center and he was given too much Morphine overnight last night. Pt had decreased LOC and has a history of dementia..." Medical record review of a hospital History and Physical dated 3/18/16 revealed "...Chief Complaint: Overdose...apparently was sent into the ER after he was difficult to arouse. There was concern he may have been given 6 times as prescribed [to] him on morphine...he was given Narcan at the facility and has some improvement...He is awake now and is answering questions..." Medical record review of a hospital Discharge Summary dated 3/23/16 revealed "...male with	N 685		

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N 685	Continued From page 9 multiple medical problems...had a history of diabetes with neuropathy and peripheral artery disease, congestive heart failure...and coronary artery disease. The patient also has mild dementia...was apparently sent to the ER after he was difficult to arouse. There was concern he may have been given 6 times as prescribed on his morphine...The patient was admitted for further evaluation and management. Discharge Diagnoses: 1. Toxic encepalopathy, likely secondary to medications...The patient's Morphine has been discontinued. The patient was placed on p.r.n. [as needed] hydrocodone. Mentation has improved..." Review of facility investigation dated 3/21/16, prepared by the DON revealed "[Resident #22] had a physician's order for Morphine Sulfate Solution 20 mg/ml 1.25 mls (25 mg) sublingually five times daily routine (7 am, 12 pm, 5 pm, 10 pm, 3 am). This concentration is what was being dispensed by the pharmacy. On 3/17/16, the last dose of this concentration was used at the 7am dose. The pharmacy was contacted and a request was made for CII [Controlled Substance Schedule II] Continuance of Therapy prescription was made. The pharmacy told the nurse that she would have to get the 12N dose from the ER Narcotic Drug Box. The concentration of the Morphine Solution in the ER Drug box is 100 mg./5 ml. [Resident #22 received 4 doses @ [at] 6ml/dose. Two nurses were involved in administering the wrong dose. When I was notified Friday, March 18, 2016 of the error, I instructed both nurses to meet with the administrator and me on Monday before returning to work. At 8:00 am [LPN #1] came in to review the incident...I questioned her about reading the label and comparing with her MAR [Medication Administration Record]. She stated that she was	N 685		

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N 685	Continued From page 10 in a hurry and didn't check...10:30 am [LPN #2] came to speak with the administrator and me about the incident that occurred with [Resident #22]. LPN #2 said that she gave 6 ml. @ the 3 am dose. When asked if she checked the label for concentration, she said no..." Interview with the Physician/Medical Director on 4/18/16 at 3:25 PM, in the conference room revealed the resident received the Morphine Sulfate due to severe general pain everywhere. Continued interview revealed the Physician had been notified the resident had received too much Morphine Sulfate on 3/17/16 and 3/18/16. Continued interview revealed the resident also had an infection at the time of the medication error. Continued interview confirmed the wrong concentration of Morphine Sulfate had been administered. Continued interview revealed some of the possible side effects of too much Morphine Sulfate included respiratory depression, lethargy, and drowsiness. Continued interview revealed on a smaller patient the dosage of Morphine Sulfate administered to Resident #22 could have been deadly. Telephone interview with LPN #2 on 4/18/16 at 10:05 PM revealed LPN #2 didn't usually work on the unit where Resident #22 resided. Continued interview revealed LPN #2 should have noted the concentration of the Morphine. Interview confirmed LPN #2 had incorrectly administered Morphine Sulfate Solution 20 mg/ml, 6 mls (120 mg) to Resident #22 on 3/18/16 at 3:00 AM. Interview with the NP (who was present on 3/18/16, when the medication error was identified) on 4/19/16 at 11:15 AM, in the conference room revealed RN #1 had notified the NP there had been an error in the administration	N 685		

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N 685	Continued From page 11 of Resident #22's Morphine Sulfate. Continued interview revealed when the NP had first examined the resident on 3/18/16, the resident was in respiratory distress. Continued interview revealed the resident had shallow breathing and was not breathing as many times per minute as the NP would like. Continued interview revealed the resident's respiratory rate had been 12 per minute and the NP would like the respiratory rate to be 16. Continued interview revealed the NP was at the resident's bedside during the time after the incorrect dosage of Morphine Sulfate had been administered to the resident the resident's oxygen saturation level had dropped to 83% and oxygen had been administered to the resident. Further interview revealed while in attendance to the resident it was discovered the resident had an elevated temperature and the NP had thought the resident might have pneumonia. Interview revealed the resident was transferred to the hospital related to fever, the resident's oxygen saturation level and blood pressure had dropped indicating the resident had some other medical condition in addition the incorrect dosage of Morphine Sulfate on 3/18/16. Telephone interview with LPN #1 on 4/19/16 at 3:15 PM revealed the facility had used all of Resident #22's Morphine Sulfate solution, the pharmacy had been contacted to obtain a code to remove the medication from the facility's ER narcotic box. Continued interview confirmed LPN #1 did not check the medication label and had incorrectly administered Morphine Sulfate Solution 20 mg/ml, 6 mls (120 mg) to Resident #22 on 3/17/16 at 12:00 PM, 5:00 PM, and 10:00 PM (3 consecutive doses). Further interview revealed on the morning of 3/18/16 CNA (#7) had reported the resident was "acting funny" however, LPN #1 had spoken to the resident and the	N 685		

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N 685	Continued From page 12 resident had said hey nurse (name) and did act a "little silly." Interview revealed the 7:00 AM dose of Morphine Sulfate on 3/18/16 was not administered to Resident #22 due to another resident had a medical emergency at that time and LPN #1 was so busy she had not administered the Morphine Sulfate to Resident #22. Interview with CNA #7 on 4/25/16 at 7:35 AM, near the nursing station revealed on 3/18/16 when the CNA had entered Resident #22's room, the resident was "hard to wake up" was confused, did not know it was morning, didn't recognize CNA #7, who routinely provided care to the resident, and had reported something was wrong with the resident to LPN #1. In summary: On 3/17/16 the facility had used all the prescribed Morphine sulfate solution ordered for Resident #22 on 3/17/16, notified the pharmacy and obtained Morphine sulfate from the ER narcotic box. LPN #1 and LPN #2 did not check the label of the Morphine sulfate to verify concentration/strength, and administered the wrong dosage (120 mg) of the Morphine sulfate to the resident for 4 consecutive doses (3/17/16 at 12:00 PM, 5:00 PM, and 10:00 PM, and on 3/18/16 at 3:00 AM). The resident suffered respiratory depression, was administered Narcan at the facility then transferred to the ER. The resident returned to the facility on 3/23/16. Medical record review revealed Resident #150 was admitted to the facility on 12/14/15 with diagnoses including Self Inflicted Gun Shot Wound to Face, Fracture of Facial Bones, Acute Respiratory Failure with Hypoxia, Muscle Weakness, and Acute Pain due to Trauma. The resident was discharged on 1/28/16.	N 685		

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N 685	Continued From page 13 Medical record review of a Physician's Order dated 12/16/15 revealed "...Start [Morphine Sulfate] 1mg SQ [subcutaneous] q 15 m [minutes] [before] wound care BID [twice a day]..." Medical record review of the Controlled Drug Record dated 12/17/15 revealed only 1 dose of the Morphine Sulfate 1 mg was signed out as administered on 12/19/15, 12/21/15, 12/23/15, 12/24/15, 12/25/15, (instead of 2 doses as ordered prior to wound care missing 5 doses) and no doses of the Morphine Sulfate was signed out as administered on 12/30/15. Medical record review of the Non Pressure Skin Condition Record dated 12/21/15 revealed "... [continue] wound care...[change] BID [twice a day]. Resident [continues] to be resistant to touching or cleaning wound but will allow to some degree if pain med given prior to [treatment]..." Interview with the DON on 4/20/16 at 1:24 PM in the conference room and review of the Controlled Drug Record confirmed the Morphine Sulfate was not administered as ordered prior to wound care. Medical record review revealed Resident #169 was admitted to the facility on 2/11/16 and readmitted on 3/3/16 with diagnosis including Motor-Vehicle Accident, Traffic, Fracture of Left Femur, Fracture of One Rib, Right Adrenal Hematoma, and Right Left Quadrant Hematoma versus Abscess, Wound Repair, Fracture of Shaft of Left Fibula, and Mental Disorder. Resident #169 was discharged home on 3/31/16. Medical record review of the Medication Record dated 3/3/16 to 3/30/16 revealed no	N 685		

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N 685	Continued From page 14 documentation Morphine Sulfate 2 mg/ml, 1 ml sq before wound care was administered. Medical record review of the Physician's Orders dated 3/4/16 revealed "Morphine Sulfate 2 mg/ml, 1 ml sq [subcutaneous] 10 min [minutes] b/f [before] wound care daily." Medical record review of the Controlled Drug Record dated 3/7/16 to 3/28/16 revealed Morphine Sulfate 2 mg/ml, 1 ml sq b/f wound care was signed out 12 times out of 26 doses ordered (14 missed doses). Interview with the Wound Care Registered Nurse on 4/20/16 at 10:00 AM, in the Conference Room revealed she asked the LPN to medicate the resident prior to wound care, returned to the LPN and asked if the resident had been medicated and proceeded with wound care. Interview with the DON on 4/22/16 at 9:50 AM in the DON office confirmed there was no documentation on the Medication Record the Morphine Sulfate was administered prior to wound care as ordered by the physician (14 doses not administered as ordered. Medical record review revealed Resident #178 was admitted to the facility on 7/17/15 with diagnoses including Osteomyelitis of Lumbar Spine, and Endocarditis. The resident was discharged on 8/25/15. Medical record review of the Physician's Recapitulation Orders dated 7/17/15 revealed "...Hydrocodone 5/325 [2] tabs po q [every] 6 [hours] as needed pain..." Medical record review of a Prescription dated	N 685		

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N 685	Continued From page 15 7/24/15 revealed "...Hydrocodone...5/325 mg [milligram] 1 tab po QID [4 times daily] PRN [as needed] pain..." Medical record review of the Pain Evaluation dated 7/24/15 revealed "...Diagnoses Related to Pain/Hurting...Generalized..." Medical record review of the Individual Patient's Controlled Substances Record revealed the resident received 2 Hydrocodone 5/325 mg from 7/25/15 to 8/4/15 (4 times tablets daily). Review of the Medication Variance Report dated 7/24/15 revealed "...Medication Involved...Hydrocodone 5/325...Original MAR [Medication Administration Record] on Admission 5/325 [2] tabs QID PRN. On 7/24/15 [Physician] wrote a new [prescription] for Hydrocodone 1 tab 5/325 po QID PRN/pain...order change for prescription not transcribed to MAR...Actions Taken Pt [patient] has received [2] tabs QID or Q 6 [hours] since admission [without] a change documentation reflecting new [prescription]..." Interview with RN (Registered Nurse)/Unit Manager #2 on 4/20/16 at 2:15 PM, in the hall confirmed the resident received 40 extra tablets of hydrocodone from 7/25/15 to 8/4/15. Interview with the DON on 4/21/16 at 8:10 AM, in the DON's office confirmed a significant medication error had occurred with the resident receiving the extra doses of the Hydrocodone. Medical record review revealed Resident #31 was admitted to the facility on 1/7/15 with diagnoses including Nontraumatic Subarachnoid Hemorrhage, Muscle Weakness, Type 2 Diabetes Mellitus, Anxiety Disorder, Major Depressive	N 685		

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N 685	Continued From page 16 Disorder and Acute and Chronic Respiratory Failure. The resident expired on 2/2/16. Medical record review of a Physician's Telephone Order dated 7/27/15 and timed 10 AM revealed "...Gentamycin [antibiotic] 80 mg IM [Intramuscular] Q [every] 12. Get trough/peak with 3rd dose [baseline for therapeutic dosing]." Medical record review of Physician's Telephone Order dated 7/29/15 and timed 0930 (9:30 AM) revealed "Hold gentamicin. Random gentamicin level in a.m. BMP [Basic Metabolic Panel] and pre-renal azotemia [abnormally high level of nitrogen in the blood]." Medical record review of Gentamicin Trough, Serum with collection date of 7/28/15 revealed result of 2.4 ug/mL (micrograms per milliliter), flagged as "High" with reference interval 0.0 - 2.0. Medical record review of Gentamicin, Random with collected date of 7/29/15 and timed 9:06 A.M. revealed result of 2.9 ug/mL. "Peak range is 5.0 - 10.0 ug/mL. Trough range is 0.5 - 2.0 ug/mL." Medical record review of the Medication Record revealed the Gentamicin was administered at 8:00 PM on 7/29/15 and at 8:00 AM on 7/30/15. Review of a Medication Variance Report dated 7/30/15 revealed "...Date and time Variance Occurred: 7-29-15...Medication involved: Order written 0930 [9:30 AM] to hold Gentamicin & [and] Obtain Random Gentamycin level in AM 7-30-15. Not taken off by nurse..." Interview with RN #2 Unit Manager on 4/21/16 at 8:36 AM, in the conference room and review of	N 685		

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N 685	Continued From page 17 the Medication Record confirmed the 8:00 PM dose of Gentamicin on 7/29/15 and the 8:00 AM dose of Gentamicin on 7/30/15 was given and should have been held per Physician's order. Interview with the Medical Director on 04/25/16 at 9:54 AM, in the conference room confirmed if an order is written to hold the Gentamicin the expectation is the dose will be held. Continued interview confirmed the order written by the nurse practitioner to hold the Gentamicin was because the Gentamicin level was elevated. Medical record review revealed Resident #93 was admitted to the facility on 10/13/15 with diagnoses including Alzheimer's, Dementia with Behaviors, Anxiety, Depression, Delusional Disorder, Diabetes Mellitus Type II, and Hypertension. Medical record review of the Vitamin D level, dated 2/1/16 revealed "...22.4 Low...ng/ml [nanogram/milliliters]...range 30.00 - 100.0..." Medical record review of the Physician's Telephone Orders dated 2/9/16 revealed "Vit [Vitamin] D 50,000 IU [international units] to be given 2 x [times] weeks. Dg [diagnosis] Vit D deficiency." Medical record review of the Medication Record dated 3/4/16 revealed "Vitamin D 50,000 IU to be given 2 x per week. Dg: VD [vitamin D] Deficiency." Further review revealed Vitamin D was administered from 3/4/16 through 3/9/16. Medical record review of the facility investigation dated 3/8/16 revealed "...wrong dose...wrong time...vit D..." Further review revealed "...done B[D [twice a day] 2 x a week supposed to be 2 x weekly daily..." Further review revealed "...order	N 685		

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N 685	Continued From page 18 improperly/not flagged as new to be taken off, chart check signed for 3/4..." Medical record review of the Medication Record dated 3/11/16 "Vitamin D 50,000 IU to be given 2 x per week dg: VD Deficiency." Interview with the DON on 4/20/16 at 12:55 PM, in the Conference Room confirmed the Vitamin D was not transcribed from 2/9/16 until 3/4/16, transcribed incorrectly resulting in 7 missed doses from 2/9/16 to 3/4/16 and from 3/5/16 to 3/9/16, 5 incorrect doses (administered 2 times a day instead of once daily twice a week). Continued Interview confirmed the facility failed to ensure the correct transcription of the Vitamin D medication. Medical record review revealed Resident #177 was admitted to the facility on 5/8/15 with diagnoses including Syncope and Collapse, Orthostatic Hypotension, Diabetes Mellitus Type II Uncontrolled, and Bipolar Disorder. Medical record review of the Physician's Telephone Orders dated 5/18/16 at 1300 (1:00 PM), revealed "...Levaquin [antibiotic] 500 mg po [by mouth] daily x [times] 7 days - UTI [Urinary Tract Infection]..." Further review revealed the order signed off by the LPN #3 on 5/18/16 at 2:15 PM. Medical record review of the facility investigation dated 5/19/16 revealed "...ordered @ [at] 1300 med should have been given by 5 pm. Avail [available] in EBox [emergency medication box]..." Medical record review of the Medication Record dated 5/16 revealed Levaquin 500 mg po daily x 7	N 685		

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N 685	Continued From page 19 days UTI the first dose administered at 8:00 AM on 5/19/16. Interview with the Unit Manager/Registered Nurse (#2) on 4/20/16 at 2:40 PM, at the 400 Nursing Station revealed the Levaquin was available in the facility to begin antibiotic treatment within 6 hours of when ordered. Interview with LPN #3 on 4/20/16 at 3:30 PM, in the conference room confirmed the medication order was signed off on 3/18/16 at 2:15 PM, and LPN #3 failed to administer the antibiotic when it was available for use in the facility.	N 685		